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IN THE

Supreme Court of the United States

OCTOBER TERM, 1986

MONSOUR MEDICAL CENTER,
Petitioner,

v.

OTIS R. BOWEN, M.D., Secretary of the United States Department of Health and Human Services, and WILLIAM L. ROPER, M.D., Administrator, Health Care Financing Administration,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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~~MOTION FOR LEAVE TO FILE BRIEF~~
AND BRIEF OF NATIONAL ASSOCIATION FOR HOME CARE, AMERICAN HOSPITAL ASSOCIATION, AND AMERICAN HEALTH CARE ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI

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MOTION FOR LEAVE TO FILE BRIEF OF NATIONAL ASSOCIATION FOR HOME CARE, AMERICAN HOSPITAL ASSOCIATION, AND AMERICAN HEALTH CARE ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI

Pursuant to Rule 36 of the Rules of this Court, the *amici curiae* seek leave to file the attached *amicus* brief in support of the petition for certiorari filed by Monsour Medical Center.[1]

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[1] Pursuant to Rule 36.1 of this Court, consent to the filing of this brief has been granted by both parties. The letters of consent have been lodged with the Clerk of the Court.

The National Association for Home Care ("NAHC") is a membership association representing over 4,000 home health agencies throughout the United States. NAHC advances the interests of home health care before the United States Congress, the courts, and federal administrative agencies. Since the major source of funding for home health care is Medicare, NAHC has dedicated a substantial proportion of its resources to assisting its members in their relations with the Health Care Financing Administration ("HCFA") and its fiscal intermediaries. NAHC has worked strenuously to develop consistent and reliable decisionmaking by the fiscal intermediaries and has encouraged strict oversight of intermediary operations by HCFA.

The role of private insurance as a payment source for home health care is growing. Many of the Medicare intermediaries, Aetna and Blue Cross, for example, are offering or developing home health care insurance as a supplement to Medicare. With these private plans, the intermediaries are structuring coverage rules and reimbursement systems along Medicare lines. Inconsistency between Medicare and private insurance regarding the proper interpretation of rules would have a dramatic effect on the efficient and effective delivery of home health care services.

The American Hospital Association ("AHA") is the primary organization of hospitals in the United States. It is a not-for-profit membership corporation organized under the laws of the State of Illinois. The principal corporate objective of the AHA is to promote high-quality health care and health care services for all people through leadership in the development of public policy, leadership in the representation and advocacy of hospital and health care organization interests, and leadership in the provision of services to assist hospitals and health care organizations in meeting the health care needs of their communities. Its membership includes

approximately 6,000 hospitals and other health care institutions, as well as approximately 35,000 individuals.

The overwhelming majority of AHA's institutional members provide health care services to Medicare patients and, accordingly, are vitally concerned with sound government policies, procedures, and requirements pertaining to the administration and operation of the Medicare program.

The AHA has no parent or non-wholly-owned subsidiary companies. Its only affiliate is the Hospital Research and Educational Trust.

The American Health Care Association ("AHCA") is the nation's largest federation of licensed nursing homes and allied long term care facilities. AHCA has 50 affiliated state associations and a District of Columbia affiliate, together representing nearly 9,000 individual facility members continuously providing nursing care and related services to approximately 900,000 elderly, convalescent and chronically ill residents. AHCA and its affiliates are non-profit associations. A majority of the nation's long term health care facilities belong to AHCA and its affiliates.

AHCA was founded in 1949 to promote standards for professionals in long term health care delivery, and quality care for residents in a safe environment and at fair payment for services. AHCA represents its members' concerns on Capitol Hill and before the federal agencies. The association assists Members of Congress and regulators in developing the policies that govern one of America's most highly regulated service sectors. One of the biggest challenges AHCA addresses is ensuring that long term care facilities have financial resources to guarantee the highest level of care delivery. Because the nursing home care provided by AHCA members is supported in part by Medicare, AHCA and its members

have a strong interest in the fair and consistent administration of that program.

The decision of the United States Court of Appeals for the Third Circuit will have potentially significant and adverse impact on the members of NAHC, AHA, and AHCA and on health care providers generally. By refusing to give collateral estoppel effect to the state court judgment, the court of appeals acted contrary to the reasonable expectations of any health care provider, and this precedent could multiply litigation for providers and leave them subject to contradictory rulings by different courts on identical issues.

CONCLUSION

For the foregoing reasons, the Court should grant leave to file the attached brief *amicus curiae*.

Respectfully submitted,

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Dated: May 4, 1987

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STATEMENT OF INTEREST

The interest of the *amici* is set forth in the foregoing Motion for Leave to File Brief as *Amici Curiae*, which is hereby incorporated by reference.

STATEMENT OF THE CASE

The *amici* incorporate by reference the statement of the case set forth in the Petition for a Writ of Certiorari of Monsour Medical Center.

REASONS FOR GRANTING THE WRIT

The *amici* support Monsour Medical Center's Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit. The Third Circuit's decision in this case, if left unreviewed, will create serious problems for the health care industry, and beyond. The Third Circuit's decision represents an erroneous view of the relationships among Medicare, fiscal intermediaries and health care providers. Because the Third Circuit failed to take account of these relationships, its ruling will injure health care providers and undermine the critical judicial policies supporting collateral estoppel.

1. The Court of Appeals Misapprehended the Relationship Among Medicare, Its Intermediaries, and Health Care Providers

The Third Circuit's decision reflects a basic misunderstanding of the relationship between Medicare and its fiscal intermediaries. For any provider, the fiscal intermediary *is* Medicare. Each intermediary has contracted with the Secretary of Health and Human Services (HHS) to determine and make Medicare payments to health care providers. 42 C.F.R. § 421.3(1986). Under the Medicare regulations, "[t]he intermediary must receive, disburse and account for funds in making Medicare payments." 42 C.F.R. § 421.100(b) (1986). In addition, it "must audit the records of providers of services." 42 C.F.R. § 421.100(c) (1986). Until terminated by the Secretary, the intermediary has sole responsibility for making Medicare payments and conducting audits. Since the intermediary is acting on behalf of the Secretary in carrying out these responsibilities, its contract with the Secretary

provides for indemnification by the federal government with respect to any actions taken on behalf of the Secretary. 42 C.F.R. § 421.5(b) (1986).

The Third Circuit also misunderstood the close ties created by fiscal intermediaries between the Medicare program and private health insurance. Many providers of health care have private insurance contracts with their fiscal intermediaries that, like the contract between Monsour Medical Center and Blue Cross of Western Pennsylvania, incorporate Medicare's cost reimbursement regulations. *Cf. Frankford Hospital v. Blue Cross of Greater Philadelphia*, 417 F. Supp. 1104, 1106 (E.D. Pa. 1976), *aff'd*, 554 F.2d 1253 (3d Cir.), *cert. denied*, 434 U.S. 860 (1977); *St. John's McNamara Hospital Organization v. The Associated Hospital Service, Inc.*, 410 F. Supp. 67, 82 (D.S.D.), *rev'd mem.*, 538 F.2d 333 (8th Cir. 1976) (noting as a factual matter that the ultimate resolution of dispute between hospital and Blue Cross Association, as fiscal intermediary, "may well affect the reimbursement formula used by [Blue Cross Association] in its dealings as a private insurer with plaintiff and with other hospitals").

These contract provisions represent the choice of fiscal intermediaries to administer their private health care programs under unitary and certain standards that are applicable to both Medicare and private insurance. The Medicare program directly benefits from this coordinated approach, moreover, since fiscal intermediaries can jointly administer their public and private insurance business and avoid expensive duplication of functions. Indeed, that is precisely what the fiscal intermediary in this case, Blue Cross of Western Pennsylvania, did.

In refusing to apply collateral estoppel in this case, the court of appeals ignored these many ties between Medicare and the intermediary/private insurer. The combination of private insurance functions with inter-

mediary responsibilities is possible only because both Medicare and the private insurers have precisely the same interests and policies in reimbursement issues. Because of this identity between the intermediary as insurer and the intermediary as intermediary, collateral estoppel is especially appropriate in this case.

2. The Third Circuit's Decision Will Incite Unnecessary Litigation For Health Care Providers And Other Parties

The potential effect of the Third Circuit's decision is not confined to the Monsour Medical Center, or to Medicare's related parties regulation. The direct effect of the Third Circuit's decision will be to increase the likelihood of litigation over cost reimbursement issues whenever the same question applies both to Medicare and to private insurer reimbursement—which often is true. This additional litigation, as in this case, may involve the application of the identical law to the identical transaction. The dangers of inconsistent pronouncements, as in this case, always will be present, along with the burdens on health care providers of more lawsuits.[1]

Health care providers, moreover, will be caught in a squeeze. Providers are dependent on reimbursement from both private insurers and Medicare. When anticipating business costs for which the provider will need reimbursement, the provider will try to meet the requirements of all applicable reimbursement standards. After the Third

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[1] The Third Circuit's decision comes at a time when the federal and state court systems are facing ever-increasing caseloads. Since 1960, for example, the number of civil cases filed in United States District Court every year has risen from approximately 58,000 to approximately 250,000. *See* Comments of Justice Scalia before the American Bar Association, as quoted in *ABA Journal*, Apr. 1, 1987, at 20.

The systemic costs of the Third Circuit's decision provide an additional reason for this Court to grant review—and to adopt a more pragmatic approach to collateral estoppel.

Circuit's ruling, however, there can be no certainty for the provider. If the fiscal intermediary in its private capacity wins a judgment in state court, that judgment will estop the hospital in a proceeding before the Provider Reimbursement Review Board (PRRB). If the fiscal intermediary loses in the private insurance context, however, the Secretary still can ignore the decision, leaving the provider to seek redetermination before the PRRB of the identical issue. Similarly, if the intermediary's ruling is tested first before the PRRB and the provider prevails, the intermediary in its private capacity is free to disregard that ruling. This heightened likelihood of inconsistent answers to the identical question greatly increases the difficulty of planning for any business.

The decision by fiscal intermediaries to administer their private health care programs under the same standard applicable to Medicare involved a balancing of benefits and burdens. Health care providers benefit from the application of a unitary and certain standard, and both providers and the intermediaries bear the risk that some reimbursement questions will be decided adversely to their interests. The Third Circuit's decision upsets this balance of benefits and burdens. By denying collateral estoppel when the provider wins the first action, even though collateral estoppel will apply when the provider loses in the first action, the Third Circuit has imposed the entire burden of uncertainty on providers. This is especially damaging because most providers are at a disadvantage in negotiating with third-party payors over contract terms, which are determined by uniform agreements that are characteristically offered on a take-it-or-leave-it basis.

The Third Circuit's decision also undermines the rule of law by its failure to address any of the interrelated policies behind collateral estoppel. Collateral estoppel seeks to "relieve parties of the cost and vexation of multiple lawsuits, conserve judicial resources, and by pre-

venting inconsistent decisions, encourage reliance on adjudication." *Allen v. McCurry*, 449 U.S. 90, 94 (1980). The prevention of inconsistent decisions is a key facet of the rule of law. This Court gave great weight to the need to preserve the rule of law when it abandoned the mutuality requirement for collateral estoppel in *Blonder-Tongue Laboratories, Inc. v. University of Illinois Foundation*, 402 U.S. 313 (1971). The ~~Court~~ stated:

> Authorities differ on whether the public interest in efficient judicial administration is a sufficient ground in and of itself for abandoning mutuality, but it is clear that more than crowded dockets is involved. The broader question is whether it is any longer tenable to afford a litigant more than one full and fair opportunity for judicial resolution of the same issue. The question in these terms includes as a part of the calculus the effect on judicial administration, but it also encompasses the concern exemplified by Bentham's reference to the gaming table in his attack on the principle of mutuality of estoppel.

Id. at 328-329 (footnote omitted).

When a court has directly passed on a question that has been fully and fairly litigated, the only object of relitigating the same issue is to gamble on achieving an outcome in conflict with the first judgment. Otherwise, the relitigation serves no purpose at all. Relitigation in pursuit of directly inconsistent decisions, however, is exactly the sort of relitigation that collateral estoppel seeks to prevent. When a second tribunal reaches a conflicting result on the same issue, it undermines the rule of law and destroys reliance on adjudication.

CONCLUSION

For the foregoing reasons, the *amici* respectfully urge that the Monsour Medical Center's petition for a writ of certiorari be granted.

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